

Distribution: Federally Qualified Health Centers (FQHCs) and Indian Health Centers (IHCs) 02-03

Issued: January 29, 2002

Subject: Federally Qualified Health Centers and Indian Health Centers Uniform Billing

Effective: March 1, 2002

Programs Affected: Medicaid

The purpose of the Uniform Billing Project (UBP) is to change how the Michigan Department of Community Health (MDCH) receives, processes, and pays Medicaid claims. This is a move toward complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the published rules regarding health care transactions and code sets. This bulletin and attached manual pages update and supersede current policies and procedures.

The attached Chapter II and Chapter III manual page revisions are necessary for the UBP and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. BIPA eliminates full-cost and enacts a prospective payment system (PPS). Any language in Chapter II referring to full-cost was changed to reflect PPS.

Providers are encouraged to keep claims up-to-date in their systems. The current proprietary electronic format, and Medicaid unique paper claim forms (MSA-1600 and MSA-1653) will not be accepted for any claims received by MDCH on and after February 1, 2002. Any FQHC professional service billed after February 1, 2002 must be converted to the HCFA 1500 paper professional claim form or the National Electronic Data Interchange Transaction Set Health Care Claim Professional 837 ASC X12N version 3051 or the Michigan Medicaid interim version 4010 (not HIPAA compliant).

February 1, 2002 marks the implementation of Current Procedural Terminology (CPT) and HCPCS Codes for FQHC professional claims. Local codes are eliminated to the extent possible so coding is consistent with industry standards. Local procedure codes for FQHCs will be end-dated upon implementation of this policy bulletin.

The changes related to the Uniform Billing Project for professional services are extensive and completely replace the previous non-standard billing instructions. As a reminder, the following are some of the changes that FQHCs must note in the revision of the Chapter IV and Bulletins MSA 01-09 and MSA 01-23:

- The Federal Employer ID or Social Security number (FE# or SSN) must be reported on all claims and must match the number on the Medicaid Provider Enrollment file associated with the billing provider ID #.
- Two-digit place of service codes are required.
- Each service reported must be billed on an individual service line for the date of service. "Series billing" is not allowed.
- Information reported to other third party payers and to MDCH is reported using the same claim format and code structure.
- MDCH relies more on CPT definitions and Centers for Medicare and Medicaid Services (CMS) guidelines for claim adjudication for many types of services. These are also consistent with other payers' standards.

Manual Maintenance

Federally Qualified Health Centers and Indian Health Centers should:


DISCARD Chapter I, II, III, IV, and V

INSERT Chapter I, II, III, IV, and V

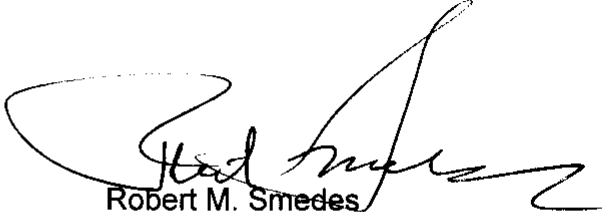
Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved



James K. Haveman, Jr.
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Robert M. Smedes
Deputy Director for
Medical Services Administration



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FOREWORD

Following is the Medicaid Manual for Federally Qualified Health Centers (FQHCs) and Indian Health Centers (IHCs). All subsequent references to FQHCs are intended to apply also to IHCs, as so designated by the Centers of Medicare and Medicaid Services. This manual gives instructions unique for FQHCs and is to be used in combination with other Medicaid provider manuals, especially the Michigan Department of Community Health's Medicaid Practitioner Manual, Chapters I, II, III, and IV.



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FEDERALLY QUALIFIED HEALTH CENTERS DESIGNATION

The Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services, determines which providers are Federally Qualified Health Centers (FQHCs) and so advises the state Medicaid Program.

An entity may qualify as an FQHC under The Health Centers Consolidation Act of 1996 which re-authorizes and consolidates the four federal health center programs (community, migrant, homeless, and public housing) under one authority, Section 330 of the Public Health Service (PHS) Act.

LEGAL REQUIREMENTS

Federally Qualified Health Centers (FQHC) - Pursuant to Section 6404 of the Federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239 [which amends Section 1902(a)(13)(E) of the Social Security Act], the Michigan Medicaid Program (Program), administered by the Michigan Department of Community Health (MDCH), will reimburse a Federally Qualified Health Center its allowable reasonable costs incurred in providing ambulatory/outpatient medical services to Medicaid beneficiaries. This policy is effective for services delivered on and after April 1, 1990.

FQHC MEMORANDUM OF AGREEMENT (MOA)

The Michigan Department of Community Health (MDCH) may enter into agreements with FQHCs. The signed agreements will supersede any corresponding policy in the Medicaid FQHC Manual.

The purpose of the MOA is to establish a new funding mechanism for FQHCs. Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid eligible beneficiaries is subject to the signed MOA between the MDCH and the FQHC. The Memorandum of Agreement is effective when both MDCH and a Federally Qualified Health Center are signatories to the MOA.

BALANCED BUDGET ACT OF 1997

Pursuant to the Balanced Budget Act of 1997, MDCH will no longer reimburse FQHCs their allowable reasonable costs incurred in providing ambulatory/outpatient medical services delivered on or after October 1, 2004.



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ENTRY INTO THE PROGRAM AS AN FQHC

FQHCs With Eligibility Date after April 1, 1990 - FQHCs must submit an acceptable cost report to MDCH by the due date of the Medicare Cost Report. If the FQHC does not submit an acceptable cost report by the due date, the FQHC waives its rights to full-cost reimbursement for that year. FQHCs not receiving full-cost for one or more years may elect to enter the Program at a later date and will be allowed full-cost for the fiscal year that an acceptable cost report is submitted.

MEDICAID PROVIDER ENROLLMENT

For a participating FQHC, each of its employed physicians, dentists, optometrists, nurse practitioners, and certified nurse-midwives under contract must be enrolled in the Medicaid Program. Any subcontracted physicians, dentists, optometrists, certified nurse practitioners, or certified nurse-midwives must be enrolled in the Medicaid Program as the FQHC's "employees" in order for each to bill for full-cost reimbursement on behalf of the FQHC.

NOTE: The FQHC must notify the Medicaid Program's Provider Enrollment Unit and Hospital & Health Plan Reimbursement Division, (see addresses in Chapter V, page 1) of any new physicians, dentists, optometrists, certified family and pediatric nurse practitioners, certified nurse-midwives, and/or subcontractors joining the FQHC. Notify the Program by attaching a copy of the original "Full-Cost Reimbursement Confirmation" letter received from Medicaid's Provider Enrollment Unit to the Medical Assistance Provider Enrollment Agreement (DCH-1625). This is the agreement that dually enrolls the Provider in the Medicaid Program and in the Full-Cost Reimbursement Program.

The FQHC must notify the Medicaid Program (Provider Enrollment Unit and Hospital & Health Plan Reimbursement Division) in a letter of any terminating physicians, dentists, optometrists, certified nurse practitioners, certified nurse-midwives, and/or subcontractors leaving the FQHC. In the letter, list the provider's name, Medicaid billing number, and termination date.

PROVIDERS "UNDER CONTRACT"

FQHC services that are furnished under contract with physicians, clinical social workers, clinical psychologists, physician assistants, certified family and pediatric nurse practitioners, visiting nurses, and other professionals are allowed to be billed as FQHC services. However, preventive primary services must be provided by an employee of the FQHC or by a physician under contract with the FQHC. Preventive primary services do not qualify as FQHC services when services are provided by non-employee providers (except physicians) contracting with the FQHC.

SITE SPECIFIC CERTIFICATION

FQHCs are required to submit proof of CMS approval letter for each site operated by the FQHC prior to enrollment of that site in the Medicaid Program. Satellite FQHC sites that are not approved by CMS are not eligible for FQHC full-cost reimbursement. Copies of approval letters from CMS must be sent to the Hospital & Health Plan Reimbursement Division. (The address is found in Chapter V, Contacts and Questions.)



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FQHC BENEFITS

The FQHC services subject to prospective payment system (PPS) reimbursement are FQHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act:

- physician services,
- services and supplies incident to physician services (including certain drugs and biologicals that cannot be self-administered),
- pneumococcal vaccine and its administration and influenza vaccine and its administration,
- physician assistant services,
- nurse practitioner and certified nurse-midwife services,
- clinical psychologist services,
- clinical social worker services,
- services and supplies incident to clinical psychologist and clinical social worker services as would otherwise be furnished by or incident to physician services, and
- other ambulatory services covered by Michigan Medicaid.

PRIMARY CARE SERVICES

Primary care services are defined as:

- Medicaid covered services provided in place of service that is the FQHC's office or clinic, Patient's Home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility by a provider type MD, DO, medical clinic, podiatrist, dentist, certified nurse practitioners or certified nurse-midwives
- Medicaid covered inpatient hospital care limited to the following procedures: Initial inpatient consultations, follow-up inpatient consultations, initial hospital care, subsequent hospital care, and newborn care
- Visits by a clinical psychologist or clinical social worker at the FQHC's office or clinic, Patient's Home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Support Services (MSS) and Infant Support Services (ISS).



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FEE-FOR-SERVICE

After entry into the Medicaid Program, each FQHC bills the appropriate Medicaid fee-for-service procedure code for Medicaid covered services for fee-for-service beneficiaries. For Medicaid services not covered by the Medicaid Health Plan contract, the FQHC may bill fee-for-service, e.g., dental.

FQHC QUARTERLY PAYMENTS

FQHCs may receive quarterly interim payments that supplement Medicaid fee-for-service and Medicaid Health Plan (MHP) or Children’s Special Health Care Services Special Health Plan (SHP) payments to FQHCs. These quarterly payments may be adjusted each year by the MDCH to account for factors such as utilization, costs, payments, and the phase-out of cost reimbursement.

ALLOWABLE VISITS PER DAY

An individual provider may be credited with no more than one visit per patient during a single day, except when the patient, after the first visit, suffers illness or injury requiring additional diagnosis or treatment. For example, a patient sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg -- those visits may be classified as two visits.

An FQHC may bill for different types of visits on the same day. For example, a patient first sees a physician at the FQHC and then sees a dentist -- those visits may be classified as two visits.



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SERVICES AND SUPPLIES INCIDENTAL TO AN FQHC VISIT

Services and supplies incident to a FQHC visit are included in the prospective payment system reimbursement if the service or supply is:

- Of a type commonly furnished in physicians' offices
- Of a type commonly rendered either without charge or included in the professional bill
- Furnished as an incidental, although integral part of professional services furnished by a physician, certified nurse practitioner, certified nurse-midwife, or licensed physician assistant
- Furnished under the direct personal supervision of a physician, certified nurse practitioner, certified nurse-midwife, or licensed physician assistant
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic

The direct personal supervision requirement is met in the case of a certified nurse practitioner, certified nurse-midwife, or licensed physician assistant only if such a person is permitted to supervise such services under the written policies governing the FQHC.

BLOOD LEAD TESTS

The blood draw in which drawing, packaging, and mailing of a blood sample are the only services provided is included in the prospective rate. Blood lead tests will not be included in the prospective payment system reimbursement because the State Blood Lead Laboratory bills the Michigan Department of Community Health directly for tests performed on Medicaid fee-for-service beneficiaries.

FLUORIDE WATER TESTS

The State Drinking Water Laboratory's charge for fluoride water testing as part of a protocol to prescribe fluoride drops for infants and children is included in the prospective payment system reimbursement as a cost incurred by the FQHC as incidental to a physician, certified nurse practitioner or nurse-midwife, or licensed physician assistant service.



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ALLOWABLE PLACES OF SERVICE

On-site services are provided to beneficiaries within the four walls of the FQHC and approved FQHC satellites.

Off-site services are provided by employed practitioners of the FQHC to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the center for health care.



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NON-ENROLLED SERVICES

Professional services provided by FQHC clinical social workers, clinical psychologists, and licensed physician assistants are reimbursed under the prospective payment system. However, these providers are not enrolled in the Medicaid Program and, accordingly, do not have their own Medicaid provider identification numbers. Bill their services under the supervising physician's Medicaid identification number. The supervising physician is responsible for the medical necessity and appropriateness of these services. The clinical psychologist and clinical social worker services are billed with the appropriate evaluation and management codes listed in the American Medical Association's Current Procedural Terminology (CPT) Manual.

All FQHCs may bill the clinical social worker and clinical psychologist services but are limited to 20 visits per beneficiary per calendar year. Visits beyond the maximum of 20 visits per beneficiary per calendar year will be rejected. Services to enrollees of a MHP must be prior authorized by the health plan.



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BILLING FEDERALLY QUALIFIED HEALTH CENTER SERVICES

FQHC services are billed using the HCFA 1500 paper claim form or the ASC X12N 837 professional electronic format. FQHCs must refer to the Practitioner Manual, Chapter IV for information needed to submit professional claims to the Michigan Department of Community Health (MDCH) for Medicaid, as well as information about how MDCH processes claims and notifies the FQHC of its action. Policies for specific services are found in Chapter III of the appropriate manuals.

MDCH STRONGLY ENCOURAGES ELECTRONIC SUBMISSION OF CLAIMS.

The MDCH approved claims will be subject to audit and verifications. Evidence of fraud will be forwarded to the Attorney General's Health Care Fraud Division for investigation.

EVALUATION & MANAGEMENT SERVICES

Providers should refer to the CPT explanations, coding conventions, and definitions for evaluation and management (E/M) services. When reporting FQHC office visits, the allowable place code is 50.

Most E/M services are payable once per day for the same patient. E/M code descriptors state "per day" in many of the categories of service; therefore, the code may be billed only once even though the patient may be seen multiple times. Only one office or outpatient visit will be reimbursed on one day for the same patient unless the visits were for unrelated reasons at different times of the day (e.g., office visit for blood pressure medication evaluation, followed 5 hours later by a visit for evaluation of leg pain following an accident.) If different levels of service are provided both times, report on one claim line with modifier 22. The time of day for each visit must be reported on the claim.

FQHCs may provide Medicaid covered services in other than the FQHC office, home, nursing facility, domiciliary facility, and a defined inpatient setting, but these services are not included in the prospective payment system. For services that are not provided in the FQHC approved setting, bill with the appropriate place code.

COORDINATION OF BENEFITS

It is the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing the Department. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid beneficiary is considered primary and must be billed according to the rules of the specific commercial plan.

The MDCH is not liable for payment of services that would have been covered by the private payer if applicable rules of that private plan had been followed. The beneficiary must seek care from network providers and authorizations or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the beneficiary to a participating provider.



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Some private commercial managed care plans involve a capitation rate and fixed co-pay amount. In this instance, it is impossible to determine a specific other insurance payment. The Department will pay a fixed co-pay amount up to our maximum allowable fee for the service.

OTHER INSURANCE AND COVERAGE PAYMENTS

All other insurance payments received for services rendered to a Medicaid beneficiary must be reported on the HCFA 1500 paper form or the ASC X12N 837 professional electronic format. Even if the other insurance payment for a specific service exceeds the amount the Program would have paid, the FQHC must still bill the fee-for-service procedure code to receive credit for an encounter.

MEDICARE AND MEDICAID CROSSOVER CLAIMS

If a Medicaid beneficiary has Medicare and Medicaid, the FQHC must follow the billing instructions in the Practitioner Manual, Chapter IV, Third Party Billing for Medicare. Even if the Medicare payment exceeds the MDCH fee screen, the FQHC must still bill the fee-for-service procedure code to receive credit for an encounter.

CO-PAYMENTS

The Medicaid co-payments for chiropractic, dental, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation. (Services requiring co-payment are listed in the Medicaid Provider manuals, Chapter I, page 21.)



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ADA VERSION 2000

FQHCs submitting paper claims must submit the American Dental Association (ADA) Version 2000 claim form for Medicaid Program reimbursement. FQHCs must refer to the MDCH Dental Manual, Chapter IV, for information regarding prior authorization instructions and claims completion.

Dentists may purchase the ADA Version 2000 claim form directly from the American Dental Association or through ADA approved vendors. The ADA claim forms will not be supplied by the Medicaid Program.

ELECTRONIC VERSION

Dental providers interested in submitting claims electronically should contact the Automated Billing Unit via e-mail at AutomatedBilling@michigan.gov for further information on electronic claims and a listing of approved service bureaus.

GLOBAL DENTAL PACKAGES

The FQHC may accept the average of encounters or submit documentation of an actual count of dental encounters with the reconciliation, e.g., complete or partial denture encounters. The quarterly payment will include as revenue an estimate of the encounters needed to reimburse for global dental packages.



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SPECIAL BILLING CONDITIONS

Global fees reimburse a package of services and are billed one time only, e.g., maternity care. The Medicaid Program is billed one service line even though the beneficiary has multiple primary care encounters to complete the follow-up work. NOTE: The global obstetric package codes include routine prenatal care, delivery and post-partum care. These codes will be paid only on a fee-for-service basis if billed. If the FQHC wishes to receive encounter payment for the prenatal care only, then the prenatal only code should be billed and the delivery code can be billed separately.

The following package prenatal codes will be assigned a number of encounters per code when billed. The FQHC may accept the averages of encounters or submit documentation of an actual count of prenatal encounters with the reconciliation.

59425 4-6 prenatal visits = 5 encounters

59426 7 or more prenatal visits = 10 encounters



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DEFINITION OF AN FQHC VISIT

An allowable FQHC visit means a face-to-face medical visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.

A visit can be between a medical provider and a patient during which medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of an illness or injury. Included in this category are physician visits and mid-level practitioner visits. Family planning medical visits are a subset of medical visits.

A visit can be between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem including restoration. A dental hygienist is credited with a visit only when the professional provides a service independently, not jointly with a dentist. However, two visits may not be billed during a patient’s visit to the dental clinic in one day.

A visit can be between a speech or physical therapist, audiologist, occupational therapist, clinical psychologist, or clinical social worker and a patient in which allied health or mental health services are provided. Allied health services are those provided by specially trained health workers, other than medical and dental personnel. Mental health services are those of a psychological or crisis intervention nature or related to alcohol or drug abuse treatment. For the purpose of these reports, visits with a psychiatrist are included under medical visits.

The following criteria help to define a visit:

1. To meet the visit criterion for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate visit.
2. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, or optician services, in and of themselves, do not constitute visits. However, these procedures may accompany services performed by medical, dental, or other health providers which do constitute visits.
3. Visits must be documented in the medical record. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in each person’s health record. This also applies to family therapy or counseling sessions in which several members of the family receive services relating to mutual family problems and the services are noted in each family member’s health record.
4. The same billing limitation identified in Chapter I of the Medicaid Provider manuals pertaining to claim submission is required of encounters.

The visit criteria are not met in the following circumstances:

1. When a provider participates in a community meeting or group session which is not designed to provide health services.



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2. When the only service provided is part of a large scale effort, such as a mass immunization program, screening program, or community-wide service program.
3. The following services are **not** classified as visits: taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling/dispensing prescriptions. Refilling prescriptions, filling out insurance forms, etc., are not visits. Allergy injection(s) are not visits.

MEDICAID HEALTH PLAN (MHP) OR CHILDREN'S SPECIAL HEALTH CARE SERVICES SPECIAL HEALTH PLAN (SHP) ENCOUNTERS

Medicaid covered services provided by a FQHC or Indian Health Center (IHC) to Medicaid eligible beneficiaries enrolled with a MHP or SHP are subject to the prospective payment system, by State cost settlement, when the following conditions are met:

- The FQHC or IHC and the MHP or SHP must be signatories to a contract which concerns the FQHC or IHC providing Medicaid covered services to the MHP or SHP enrollee.
- The contract must provide for the MHP or SHP to reimburse the FQHC or IHC at a fair market rate for similarly situated beneficiaries served by a non-full cost provider. The contractor must implement a payment method equal to, or above that of, other affiliated inter-plan and intra-plan subcontracting arrangements when entering into a subcontract with an FQHC or IHC.
- The FQHC or IHC must request that the Department pay the prospective payment rate for MHP or SHP enrollees.

The FQHC or IHC must file an FQHC Medicaid Cost or Reconciliation Report with the Michigan Department of Community Health, Hospital & Health Plan Reimbursement Division. In the Cost Report, the full-cost provider must indicate:

- the number of primary care member months,
- the number of Medicaid only primary care encounters,
- the number of Medicare and Medicaid primary care encounters,
- the amount of primary care payments from MHPs or SHPs, and
- all other payments from MHPs or SHPs.

The full-cost provider must, upon request, forward to the MDCH, Hospital & Health Plan Reimbursement Division, its MHP or SHP contract.

Given verifications, the difference between FQHC or IHC cost and MHP or SHP payments will be full-cost reimbursed by the Department.



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The provider is not able to bill its supplementary code for MHP or SHP beneficiaries, and the MDCH will settle and pay its share of reimbursement owed on a quarterly basis.

The contract and all FQHC or IHC services are subject to field audit and verifications.

MHP or SHP beneficiaries are identified by a Level of Care Code 07 or Code 11 on the beneficiary's Medicaid ID card.



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MEDICAID COST REPORT

The Michigan Department of Community Health will cost settle the primary care services as defined in the FQHC manual.

Medicaid covered services not defined as primary care services are not cost settled. For non-primary care services, the FQHC will receive the Medicaid fee-for-service amounts or the amount agreed to with the MHP or SHP as payment in full. The FQHC may enter into a risk contract with the MHP or SHP for services not included in the primary care definition. Risk contracts will not be cost settled.

MEMORANDUM OF AGREEMENT (MOA) QUARTERLY ADVANCES

MDCH will establish a quarterly interim payment for each FQHC. This quarterly amount may be adjusted periodically by MDCH to account for changes in the payment limits, cost, utilization and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment that may be implemented if approved by MDCH. The quarterly payment will be counted as Medicaid revenue at the end of the period and will be reconciled with the FQHC reimbursable cost in the cost settlement process.

OTHER QUARTERLY ADVANCES

FQHCs that choose **not** to sign the MOA will receive a retrospective quarterly interim payment based on actual cost, encounters, and payments.



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FQHCS THAT SIGN THE MOA

The Medicaid limit per encounter for primary care full-cost services is the lessor of actual cost or the annual Medicare FQHC upper payment limit plus an add-on rate of \$17.00. In 2001, the \$17.00 add-on rate will be adjusted by the percentage change in the Medicare Economic Index (MEI) from the year 2000. For each subsequent year, the MEI will be applied to the previous year's add-on rate. The Medicaid limit per encounter applies to the following services:

- Medicaid covered services provided in place of service Doctor's office or Clinic, Patient's Home, Domiciliary Facility Nursing Home and Skilled Nursing Facility by provider types MD, DO, Medical Clinic, Podiatrist, Dentist, Certified Nurse Practitioner, and Certified Nurse-Midwife
- Medicaid covered inpatient hospital care limited to the following procedures: Initial inpatient consultations, follow-up inpatient consultations, initial hospital care, subsequent hospital care, and newborn care
- Visits by a clinical psychologist or clinical social worker
- Dental
- Maternal Support Service (MSS) and Infant Support Service (ISS)

FQHCs will receive reasonable full cost for other ambulatory services, i.e., Medicaid transportation and outreach.



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FQHCS THAT DO NOT SIGN THE MOA

The Medicaid limit per encounter for primary care full-cost services is defined as the lessor of actual costs or the annual Medicare upper payment limit. The Medicaid limit per encounter applies to the following services:

- Medicaid covered services provided in place of service Doctor’s office or Clinic, Patient’s Home, Domiciliary Facility Nursing Home and Skilled Nursing Facility by provider types MD, DO, Medical Clinic, Podiatrist, Certified Nurse Practitioner, and Certified Nurse-Midwife
- Medicaid covered inpatient hospital care limited to the following procedures: Initial inpatient consultations, follow-up inpatient consultations, initial hospital care, subsequent hospital care, and newborn care
- visits by a clinical psychologist or clinical social worker

FQHCs will receive reasonable full cost for other ambulatory services, e.g., Medicaid transportation, outreach, dental, and Maternal Support Service (MSS) and Infant Support Service (ISS). Pursuant to the Balanced Budget Refinement Act of 1999, Section 603(a), “Modification of the Phase-Out of Payment for Federally Qualified Health Centers and Rural Health Clinic Services based on Reasonable Costs,” MDCH will pay 95% of reasonable primary care full costs for services furnished during fiscal year (FY) 2000, 95% for FY 2001, 95% for FY 2002, 90 % for FY 2003, and 85% for FY 2004. For the 12-month period 10-01-03 to 9-30-04, all FQHCs will receive 85% of cost. Cost-based reimbursement will be repealed effective October 1, 2004.

PRORATING THE MEDICAID LIMIT

For all FQHCs that have a fiscal year ending other than December, the maximum limit will be prorated based on the number of fiscal year months in each calendar year.

MEDICAID COST REPORTING

The FQHC or IHC must complete an FQHC Medicaid Cost Report for its fee-for-service and MHP or SHP enrollees. The FQHC Medicaid Cost Report covers actual costs for services to Medicaid beneficiaries and is based on the latest fiscal period of operation of the facility.

The FQHC Medicaid Cost Report must be received by the MDCH's Hospital & Health Plan Reimbursement Division by the due date for the Medicare Cost Report.

Each FQHC Medicaid Cost Report must be signed by the authorized individual who certifies the cost report and accompanying worksheets for the period noted. If the required cost report and supplemental documents are not submitted within the required time limit, the FQHC and IHC waives its rights to full-cost for that year.



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ACCOUNTING AND RECORD KEEPING

The FQHC Medicaid Cost Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.

REASONABLE COSTS

Reasonable and allowable costs will be determined in accordance with applicable Medicare cost reimbursement principles, as defined by federal regulation at 42 CFR, Section 413.

MEDICAL AND FINANCIAL RECORDS

The FQHC must maintain, for a period of not less than six years, financial and clinical records for the period covered by the cost report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or they will be disallowed.

The MDCH Hospital & Health Plan Reimbursement Division will maintain each required FQHC Medicaid Cost Report submitted by the provider for six years following the date of submission of the report. In the event that there are unresolved issues at the end of this six-year period, the cost report will be maintained until such issues are resolved.

The financial and clinical records of the FQHC must be available for review by authorized personnel or agents of the Michigan Department of Community Health, Health Care Fraud Division of the Michigan Department of Attorney General; the United States Department of Health and Human Services in conformity with the provisions of the Social Security Act.

DETERMINATION OF COSTS

Costs and settlements will be determined using the FQHC Medicaid Cost Report and paid claim data which is obtained by the Hospital & Health Plan Reimbursement Division (see address in Chapter V, Contacts and Questions).



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QUARTERLY ADVANCES

FQHCs will be paid quarterly advances during the first week of each fiscal quarter.

RISK CONTRACTS

The FQHC may enter into risk contracts with a Medicaid Health Plan (MHP) or Special Health Plan (SHP) for services not included in full cost. Risk contracts will not be cost settled.



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INITIAL SETTLEMENTS OF FQHCS

An initial settlement will be calculated annually from the cost of services provided for fee-for-service beneficiaries or non MHP or SHP services, e.g., dental. Calculations are determined from the filed FQHC Medicaid Cost Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable cost report. MDCH retains the right to withhold a portion of an initial payment based on individual circumstances.

FINAL SETTLEMENTS OF FQHCS

Final settlements for FQHCs will be completed generally within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Cost Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

The Medicare intermediary field and/or desk audit may cause MDCH to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDCH may process a revised Medicaid final settlement for the period covered by the cost report.

UNDERPAYMENTS TO FQHCS

MDCH staff will process the full amount of the final settlement through a gross adjustment.

OVERPAYMENTS TO FQHCS

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and shall be recovered by MDCH. The recovery will start approximately 30 days after notification to the FQHC. A credit gross adjustment will stop all payments to the FQHC physician(s) until the amount is recovered.

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid settlements.



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AUDIT ADJUSTMENT REPORT FOR FQHCS

MDCH staff prepare the Audit Adjustment Report which contains a descriptive list of all Program data adjustments made to the Medicaid Cost Report by MDCH audit staff.

FQHC ACCEPTS AUDIT ADJUSTMENT REPORT

If the FQHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the FQHC must sign the report and mail it to:

HOSPITAL & HEALTH PLAN REIMBURSEMENT DIVISION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30479
LANSING MI 48909-7979

A Notice of Amount of Program Reimbursement will be mailed to the FQHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.

FQHC NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration.

FQHC DOES NOT RESPOND TO AUDIT ADJUSTMENT REPORT

The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date. If the FQHC has not responded within this time period, MDCH shall issue a Notice of Amount of Program Reimbursement which is the final determination of an adverse action. No further administrative appeal rights are available.

FQHC REJECTS AUDIT ADJUSTMENT REPORT

If the FQHC rejects any or all of the findings contained in the Audit Adjustment Report, the FQHC may request a Post-Audit Conference within 30 calendar days from the date of receipt of the Audit Adjustment Report.



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MEDICAID PROVIDER APPEALS

The Medicaid provider has the right to appeal any adverse action taken by the Michigan Department of Community Health (MDCH) unless that adverse action resulted from an action over which the MDCH had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the Medicaid All Providers, Chapter I, and in the "Department's Medicaid Provider Reviews and Hearings" rules, R400.3401 through R400.3424, filed with the Secretary of State on March 7, 1978. Any questions regarding this appeal process should be directed to the Administrative Tribunal at (517) 335-9384.



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CONTACTS AND QUESTIONS

Billing problems regarding physician services may be directed to the Provider Information Line 1-800-292-2550.

Any lengthy or unusual problems may be mailed to the Program Support Unit. The Program Support Unit researches and responds to written and email inquiries relating to billing and reimbursement problems.

MAIL: PROGRAM SUPPORT UNIT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30479
LANSING MI 48909-7979

EMAIL: providersupport@michigan.gov

Any rate setting or cost settlement related questions may be directed to the Hospital & Health Plan Reimbursement Division at (517) 335-5330 and FAX (517) 241-7408.

MAIL: HOSPITAL & HEALTH PLAN REIMBURSEMENT DIVISION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30479
LANSING MI 48909-7979

Medicaid Provider Enrollment Unit maintains provider enrollment information. Provider enrollment inquiries may be directed to Provider Enrollment at (517) 335-5492 and FAX (517) 241-8233.

MAIL: PROVIDER ENROLLMENT UNIT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

Application for FQHC Status may be made to U.S. Department of HHS at (312) 353-8700.

MAIL: Brenda Tucker-Jeffries
HEALTH RESOURCE SERVICES ADMINISTRATION
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
233 N. MICHIGAN AVENUE SUITE 200
CHICAGO, ILLINOIS 60601



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